INDIRECT CARE COST CENTER

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:

	INDIRECT CARE COST CENTER	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col. 3) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. Ratio *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	ADMINISTRATIVE & GENERAL SERVICES								
34.	Laundry/Housekeeping Supervisor	7240							
35.	Housekeeping	7245							
36.	Laundry and Linen	7250							
37.	Universal Precaution Supplies	7255							
38.	Legal Services	7260							
39.	Accounting	7265							
40.	Dues, Subscriptions and Licenses	7270							
41.	Interest - Other	7275							
42.	Insurance	7280							
43.	Data Services	7285							
44.	Help Wanted/Informational Advertising	7290							
45.	Amortization of Start-Up Costs	7295							
46.	Amortization of Organizational Costs	7300							
47.	Other Indirect Care - Specify below	7305							
48.	** Home Office Costs/Indirect Care **	7310							
49.	TOTAL Admin. & General Services (sum of lines 34 thru 48 and 33)								
	MAINTENANCE AND MINOR EQUIPMENT								
50.	Plant Operations/Maintenance Supervisor	7320							
51.	Plant Operations and Maintenance	7330							
52.	Repair and Maintenance	7340							
53.	Minor Equipment	7350							
54.	Leased Equipment	7400							
55.	TOTAL Maintenance and Minor Equipment (sum of lines 50 through 54)								
	PAYROLL TAXES, FRINGE BENEFITS, & STAFF DEVELOPMENT								
56.	Payroll Taxes - Indirect Care	7500							
57.	Workers' Compensation - Indirect Care	7510							
58.	Employee Fringe Benefits - Indirect Care	7520							
59.	EAP Administrator - Indirect Care	7525							
60.	Self Funded Prog. Admin. - Indirect Care	7530							
61.	Staff Development - Indirect Care	7535							
62.	TOTAL Payroll Taxes, Fringe Benefits, & Staff Development (sum of lines 56 thru 61)								
63.	TOTAL Reimbursable Indirect Care Cost (sum of lines 18, 25, 49, 55 and 62)								

** Home office costs are to be entered on line 48 only. They are not to be distributed to any other line on this schedule. **

Line 47 Other Indirect Care - Specify below

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 47, Cols 1 & 2		

*** If ratios of allocation are used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

ODHS 2524 (REV. 8/97)

TN #98-08 APPROVAL DATE MAY 28 1998
SUPERSEDES
TN #9705 EFFECTIVE DATE 3/31/98

INDIRECT CARE COST CENTER

Provider Name:	Medicaid Provider Number	Reporting Period From:	Through:

	NON-REIMBURSABLE EXPENSES	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. Ratio *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	NURSING FACILITIES ONLY NON-REIMBURSABLE EXPENSES								
64.	Physical Therapist - NF	6600							
65.	Physical Therapy Assistant - NF	6605							
66.	Occupational Therapist - NF	6610							
67.	Occupational Therapist Assistant - NF	6615							
68.	Speech Therapist - NF	6620							
69.	Audiologist - NF	6630							
70.	Payroll Taxes - Therapy - NF	6640							
71.	Workers' Compensation - Therapy - NF	6650							
72.	Employee Fringe Benefits - Therapy - NF	6660							
73.	EAP Administrator - Therapy - NF	6665							
74.	Self Funded Program Admin. - Therapy-NF	6670							
75.	Staff Development - Therapy - NF	6680							
76.	TOTAL Non-Reimbursable NF's Only (sum of lines 64 through 75)								
	NURSING FACILITIES & ICF's-MR NON-REIMBURSABLE EXPENSES								
77.	Legend Drugs	9705							
	Radiology	9710							
	Laboratory	9715							
80.	Oxygen	9720							
81.	Other Non-Reimbursable - Specify below	9725							
82.	Late Fees, Fines or Penalties	9730							
83.	Federal Income Tax	9735							
84.	State Income Tax	9740							
85.	Local Income Tax	9745							
86.	Insurance - Officer's Life	9750							
87.	Promotional Advertising and Marketing	9755							
88.	Contributions and Donations								
89.	Bad Debt								
90.	Parenteral Nutrition Therapy	9770							
91.	TOTAL Non-Reimbursable NF's and ICF's-MR (sum of lines 77 thru 90)								
92.	TOTAL Non-Reimbursable NF's and ICF's-MR (sum of lines 76 and 91)								
93.	TOTAL Indirect Care Cost Reimbursable and Non-Reimbursable (sum of lines 63 and 92)								

Line 81 Other Non-Reimbursable - Specify below

Account Title	Salary Column 1	Other Column 2
's must tie to line 81, Cols 1 & 2		

***If ratios of allocation are used, limit the precision to four places to the right of the decimal.

NOTE: ALL COST DATA SHOULD BE ROUNDED TO THE NEAREST WHOLE DOLLAR.

ODHS 2524 (REV. 8/97)

TN #98-02 APPROVAL DATE MAY 2 8 1998
SUPERSEDES
TN #97-05 EFFECTIVE DATE 3/31/98

ADMINISTRATORS COMPENSATION

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:

SECTION A:

Name of Individual	Administrator License Number*	Social Security No.

Relationship to Provide Is the administrator an owner/relative? Yes _____ No _____

1.	Base percentage allowance		100%
2.	Years of work experience in related work area, if administrative, must be in health care field (not to exceed 10 years).	_____ Times 4	%
3.	Years of formal education beyond high school (not to exceed six years if baccalaureate degree is obtained or four years if baccalaureate in not obtained)	_____ Times 5	%
3.1	Was baccalaureate degree obtained? ___ Yes _____ No		
4.	Duties other than those normally performed by this position where a salary is not declared (not to exceed four extra duties)		
	a. Accounting		
	b. Maintenance		
	c. Housekeeping		
	d. Other, specify		
	e. Other, specify		
	Total Duties	Times 4 =	%
5.	County Adjustment (see instructions)		%
6.	Ownership Points (see instructions)		%
7.	Subtotal of lines 1 through 6		%
8.	Allowance Percentage (enter line 7, not to exceed 150%).		%

SECTION B:

This Administrator's Dates of Employment During This Reporting Period		Worked Weekly		Account Number ***	Col. No.	Compensation Amount
Beginning (MMDDYY) (1)	Ending (MMDDYY) (2)	Hrs. ** (3)	% (4)	(5)	(6)	(7)
TOTAL						

* QMRP'S AND ADMINISTRATORS OF HOSPITAL BASED LTCF'S REPORT SOCIAL SECURITY NUMBER.

** REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN 7 IS ALLOCATED. HOURS WORKED MUST BE ALLOCATED USING THE SAME RATIO.

*** THIS SCHEDULE MUST BE COMPLETED FOR ALL ADMINISTRATORS REGARDLESS OF WHETHER THE ADMINISTRATOR'S SALARY IS REPORTED IN ACCOUNT NUMBER 7200 OR ACCOUNT NUMBER 7310. (USE ONLY ACCOUNT NUMBER 7200 OR 7310, WHICHEVER IS APPROPRIATE.)

TN # 98-12 APPROVAL DATE MAY 28 1998
SUPERSEDES
TN # 97-05 EFFECTIVE DATE 3/8/98

Attachment 4.19D
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Appendix A
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ODHS 2524
Schedule C-2
1 of 2

OWNERS/RELATIVES COMPENSATION

Instructions: If no compensation is reported do not complete this form, otherwise all items within this schedule must be completed.
Detail owner and/or relatives compensation included on ODHS 2524, Schedules B-1, B-2 and C net of applicable col. 4 adjustments.

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:

Individual's Name (1)	Social Security Number. (2)	Position Number ** (3)	Relationship to Owner (4)	Years of Exper. (5)	Dates of Employment During this Reporting Period		Worked Weekly		Account Number (10)	Compensation	
					Beginning (6)	Ending (6)	Hrs. * (8)	% (9)		Col. No. (11)	Amount (12)

MAY 28 1998
APPROVAL DATE 3/31/98
EFFECTIVE DATE
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SUPERSEDES
TN # 92-56

* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN 6 IS ALLOCATED HOURS WORKED MUST BE ALLOCATED USING THE SAME RATIO.

** SEE COST REPORT INSTRUCTIONS PAGES 7, 8, 9 FOR POSITION NUMBERS.

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OWNERS/RELATIVES COMPENSATION

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:

Instructions: All items within this schedule must be completed. List all compensation received from other long-term care facilities in the Medicaid program (in Ohio or other states) by persons listed on Sch. C-2, page 1 of 2, and/or owning a 5% or more interest in this facility.

Individual's Name (1)	Social Security Number (2)	Facility Name (3)	No. of Beds (4)	Medicaid Provider No. " (5)	Worked Weekly Hrs (6) *	Worked Weekly % (7)	(8)

* Report the number of hours consistent with the compensation reportd. If the amount in column 9 is allocated, hours worked must be allocated using the same ratio.

ODHS 2524 (REV. 8/97)

TN #98-09 APPROVAL DATE MAY 28 1998

8/31/98

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Appendix A
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COST OF SERVICES FROM RELATED ORGANIZATIONS *

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:

1. In the amount of costs to be reimbursed by the Ohio Medical Assistance Program, are any costs included which are a result of transactions with a related organization? *

_____ Yes _____ No If yes, complete item 2.

2. Does this cost report include payments to related parties in excess of the costs to the related party?

_____ Yes _____ No If yes, complete the table below.

Name of Owner (1)	Social Security No. (2)	Name of Related Orginization (3)	Federal ID. No. (4)	Percent Ownership (5)	Account Number (6)	Item (7)	Actual Cost Claimed on this Cost Report (8)	Cost to Related Organization (9)

* FOR FURTHER EXPLANATION SEE OAC RULE 5101:3-3-20

ODHS 2524 (REV. 8/97)

TN # 96-02 APPROVAL DATE MAY 28 1998
SUPERSEDES TN # 97-16 EFFECTIVE DATE 8/1/97

COST OF SERVICES FROM RELATED ORGANIZATIONS

Name of Facility	Medicaid Provider Number	Reporting Period From:	Through:

3. List each individual who owns, in whole or in part, any mortgage or deed of trust, of the facility or of any property or asset of the provider. (All individuals owning greater than 10% of the land or building, and/or greater than 5% of non real estate business, etc., must be identified by name and Social Security Number.) *

Name	Social Security Number	Name	Social Security Number

4. Is this facility a partnership? _____ Yes _____ No If yes, list each partner.
Is this facility a corporation? _____ Yes _____ No If yes, list each corporate officer or director. **

Name	Social Security Number	Job Title

5. List all other facilities that have ownership, either direct or indirect, in common with this facility.

Provider Name	Provider Number	Number of Beds	Provider Name	Provider Number	Number of Beds

6. Has any director, officer, manager, employee, individual or organization having a direct or indirect ownership interest of 5% or more, been convicted of a criminal or civil offense related to their involvement in programs established by the Title XVIII (Medicare), Title XIX (Medicaid), or Title XX of the Social Security Act as amended?
_____ Yes _____ No If yes, list names below.

Name	Social Security Number	Name	Social Security Number

7. Has any individual currently under contract with the provider or related party organization been employed in a managerial, accounting, auditing, legal, or similar capacity by the Ohio Department of Human Services, Ohio Department of Health, Office of the Attorney General, the Ohio Department of Aging, or the Department of Industrial Relations within the previous twelve months?
_____ Yes _____ No If yes, list names below.

Name	Social Security Number	Name	Social Security Number

* FOR FURTHER EXPLANATION SEE OAC RULE 5101:3-3-20.
** FOR CORPORATE OFFICERS OR DIRECTORS NOT IDENTIFIED IN 1, 2 OR 3 ABOVE AND WHO HAVE NOT RECEIVED COMPENSATION FOR PERFORMING THE DUTIES OF CORPORATE OFFICER OR DIRECTOR, NEED NOT REPORT THEIR SOCIAL SECURITY NUMBER.

ODHS 2524 (REV. 8/97)

Appendix A
Enacted

CONTRACT FOR SERVICE

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:

8. Providers are required to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is twenty-five thousand dollars or more in a twelve month period, or for the services of a sole proprietor or partnership where there is no cost incurred and the imputed value of the service is twenty-five thousand dollars or more in a twelve-month period, the audit provisions of 42 CFR, subpart (D) apply to these contractors.

Pursuant to the Ohio Administrative Code Rule 5101:3-3-20(N)(1), "Contract for Service" is defined as the component of a contract that details services provided, exclusive of supplies and equipment. It includes any contract which details services, supplies, and equipment to the extent the value of the service component is twenty-five thousand dollars or more in a twelve-month period.

Pursuant to the Ohio Administrative Code Rule 5101:3-3-20(N)(2), "Subcontractor" is defined as any entity, including an individual or individuals, that contract with a provider to supply a service, either to the provider or directly to the beneficiary, for which Medicaid reimburses the provider the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is twenty-five thousand dollars or more in a twelve-month period.

Please complete the information requested below:

Contractor Name	Contract Amount	Goods or Services Provided

** FOR FURTHER EXPLANATION SEE OAC RULE 5101:3-3-20

ODHS 2524 (REV. 8/97)

CAPITAL COST CENTER

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

All ICFs-MR need only use group (A).

NFs that did not change provider agreement on or after 7/01/93 need only use group (A).
NFs that did change provider agreement on or after 7/01/93 use groups (A) and (B).

GROUP A ASSETS ACQUIRED

OWNERSHIP COST CENTER (1)	Chart of Account (2)	Total (3)	Adjusted Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. Ratio *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
1. Depreciation - Building	8010					
2. Amortization - Land Improvements	8020					
3. Amortization - Leasehold Improve.	8030					
4. Depreciation - Equipment	8040					
5. Depreciation - Transportation Equip.	8050					
6. Lease and Rent - Building	8060					
7. Lease and Rent - Equipment	8065					
8. Interest Exp. - Prop., Plant & Equip.	8070					
9. Amortization of Financing Costs	8080					
10. ** Home office Costs/Capital Cost **	8090					
11. TOTAL Cost of Ownership Group A						

** Home Office Costs are to be entered on line 10 only. They are not to be distributed to any other line in Group A. **

C IP A RENOVATIONS

RENOVATIONS (1)	Chart of Account (2)	Total (3)	Adjusted Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. Ratio *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
12. Depreciation/Amort & Interest	8500,8570,8580					
13. TOTAL RENOVATIONS GROUP A						

GROUP B ASSETS ACQUIRED THROUGH A CHANGE OF PROVIDER AGREEMENT

NFs, other than leased facilities, that changed Provider Agreement on or after 7/01/93 use this group to report expenses incurred through a change of provider agreement on or after 7/01/93. Leased nursing facilities that changed provider agreement on or after 5/27 use this group to report expenses incurred through a change of provider agreement on or after 5/27/92.
[Use column (4) to adjust reported costs to the allowable costs as defined in OAC 5101:3-3-516.]

OWNERSHIP COST CENTER (1)	Chart of Account (2)	Total (3)	Adjusted Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. Ratio *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
14. Depreciation - Building	8110					
15. Depreciation - Equipment	8140					
16. Interest Exp. - Prop., Plant & Equip.	8170					
17. Amortization of Financing Costs	8180					
18. Lease Expense	8195					
19. TOTAL Cost of Ownership Group B						

*** If ratios of allocation are used, limit the precision to four places to the right of the decimal.

All cost data should be rounded to the nearest whole dollar.

TN #98-02 APPROVAL DATE MAY 2 8 1998
SUPERSEDES
TN #92-05 EFFECTIVE DATE 8/1/98

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

All ICFs-MR need only use group (A).

NFs that did not change provider agreement on or after 7/01/93 and are not held harmless under 5101:3-3-517 of the Administrative Code need only use group (A).
NFs that did change provider agreement on or after 7/01/93 use groups (A) and (B).
NFs that qualify to be held harmless under rule 5101:3-3-517 of the Administrative Code use groups (A) for assets acquired on or after 7/01/93 and (C) for assets acquired prior to 7/01/93.

GROUP A — ASSETS ACQUIRED

	ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period [Col 2 + Col 3] (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period [Col 4 - Col 5] (6)	Depreciation this Period (7)
1.	Land							
2.	Buildings							
3.	Land Improvements							
4.	Leasehold Improvements							
5.	Equipment							
6.	Transportation							
7.	Financing Costs							
8.	TOTAL							

Has there been any change in the original historical cost of capital assets? YES ☐ NO ☐
If yes, submit complete detail.

GROUP A — RENOVATIONS

Complete for renovations in use during cost report period reimbursable under OAC Rules 5101:3-3-51 and 5101:3-3-84.

	ACCOUNT - RENOVATIONS							
(1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Project Cost End of Period [Col 2 + Col 3] (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period [Col 4 - Col 5] (6)	Depreciation this Period (7)	Interest this Period (8)	Total Columns 7 and 8 (9)**
9.								
10. TOTAL								

** Transfer TOTAL of column 9 to the appropriate period on Schedule D, column 3, line 12.

GROUP B — ASSETS ACQUIRED THROUGH A CHANGE OF PROVIDER AGREEMENT

NFs, other than leased facilities, that changed Provider Agreement on or after 7/01/93 use this group to report expenses incurred through a change of provider agreement on or after 7/01/93.

	ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period [Col 2 + Col 3] (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period [Col 2 - Col 5] (6)	Depreciation this Period (7)
11.	Land							
12.	Buildings							
13.	Equipment							
14.	Financing Costs							
15.	TOTAL							

Has there been any change in the original historical cost of capital assets? YES ☐ NO ☐
If yes, submit complete detail.

TN #98-02 APPROVAL DATE MAY 28 1998
SUPERSEDES
TN #92-05 EFFECTIVE DATE 3/1/92